Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GREAT HOUSTON ER PHYSICIANS
PO BOX 200472
HOUSTON TX 77216

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-13-0276-01

MFDR Date Received
SEPTEMBER 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary with the request for medical fee dispute resolution.

Amount in Dispute: $275.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's Exhibit D indicates the bill for that date of service was filed to Texas Mutual on 3/22/12. Ninety-five days from 11/18/11 is 2/21/12. The bill is untimely. Review of the requestor's DWC-60 packet reflects that the exception criteria at 408.0272 of the Labor code do not apply in this case. No payment is due."

Response Submitted by: Texas Mutual Insurance Co., 6210 E Hwy. 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 18, 2011	Emergency Room Services	$275.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 724 – No additional payment after a reconsideration of services.

Issues

1. Is the date of service eligible for review?

Findings

1. 28 Texas Administrative Code §133.307(2) states in part, "The provider shall file the request for MFDR Section by any mail service or personal delivery. The request shall include: (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)...." Review of the documentation submitted by the requestor finds that the original and reconsideration bills for the disputed date of service were not included in the dispute package; therefore, this date is ineligible for review.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 31, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.